Section 6: Prior Approval

Prior approval (PA) may be required for some services, products, or procedures to verify documentation of apparent medical necessity. All requests for PA must be submitted in accordance with DMA's clinical coverage policies and published procedures (but see discussion under **Early and Periodic Diagnostic, Screening and Treatment** in this section). PA is for medical approval only. PA must be obtained **before** rendering a service, product, or procedure that requires PA. Obtaining PA does not guarantee payment, ensure recipient eligibility on the date of service, or guarantee that a post-payment review to verify that the service was appropriate and medically necessary will not be conducted. A recipient must be eligible for Medicaid coverage on the date the procedure is performed or the service rendered.

The recipient must meet all medical necessity PA criteria. **However**, the federal Social Security Act (the Act) found at 1905(r) requires the state Medicaid agency to provide to Medicaid recipients under 21 years of age "necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." Additionally, if the recipient is under 21 years of age, service limitations on scope, amount, duration, and/or frequency and other specific criteria described in clinical coverage policies may be exceeded or may not apply provided that documentation shows the requested service is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified by a licensed clinician. This special provision for recipients under 21 years of age is known as Early and Periodic Screening Diagnostic and Testing (EPSDT). EPSDT criteria are specified below, and **all criteria must be met to approve coverage under EPSDT**. A list of EPSDT services is located in this section.

1. EPSDT services must be coverable services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. For example, "rehabilitative services" are a covered EPSDT service, even if the particular rehabilitative service requested is not listed in DMA clinical policies or service definitions.
2. The service must be medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] diagnosed by the recipient's physician, therapist, or other licensed practitioner. By requiring coverage of services needed to correct or ameliorate a defect, physical or mental illness, or a condition [health problem], EPSDT requires payment of services that are medically necessary to sustain or support rather than cure or eliminate health problems to the extent that the service is needed to correct or ameliorate a defect, physical or mental illness, or condition [health problem].
3. The requested service must be determined to be medical in nature.
4. The service must be safe.
5. The service must be effective.
6. The service must be generally recognized as an accepted method of medical practice or treatment.
7. The service must not be experimental/investigational.

Additionally, services can be covered only if they are provided by a N.C. Medicaid–enrolled provider for the specific service. For example, only a N.C. Medicaid–enrolled durable medical equipment (DME) provider may provide DME to a Medicaid recipient. This may include an out-of-state provider who is willing to enroll if an in-state provider is not available.

If a service, product, or procedure requires PA, requests made on behalf of recipients under 21 years of age are **NOT** exempt from the PA requirement. Further information about EPSDT is available in **Section 2** of this billing guide, the PA table and list of EPSDT services found in this section, and DMA's EPSDT Policy Instructions Update, on the web at http://www.ncdhhs.gov/dma/EPSDTprovider.htm

To determine if a procedure requires PA, refer to DMA's clinical coverage policies, listed on DMA's website at http://www.ncdhhs.gov/dma/mp/mpindex.htm. Providers may also call the Automated Voice Response (AVR) system at 1-800-723-4337. Refer to **Appendix A** for information on using the AVR system.

Important Points about Prior Approval

1. **In accordance with 10A NCAC 22J.0106(d), providers cannot bill recipients when the provider failed to follow program regulations.**
2. Retroactive PA is considered when a recipient, who does not have Medicaid coverage at the time of the procedure, is later approved for Medicaid with a retroactive eligibility date. Exceptions **may apply** as indicated below.
   a. Recipients enrolled in a Community Alternatives Program (CAP)
   b. Hospice Election Reporting PA. Refer to Medicaid's Clinical Coverage Policy #3D, *Hospice Services,* on DMA's website for further information. The web address is http://www.ncdhhs.gov/dma/mp/mpindex.htm
   c. If a recipient has been placed in a nursing facility, the PA date for nursing facility level of care may be retroactive to 30 days prior to the date the FL2 is approved by the fiscal agent or up to 90 days with the FL2 and supporting records.
3. Prior approval numbers are issued to the provider who submits the request. If a claim is billed for a prior approved service by a different provider, it will be denied. If a recipient changes providers before the approved service or procedure is completed, the new provider must submit a new prior approval request before the service is rendered. The new provider may include documentation that was submitted by the previous provider.
4. Before admitting recipients for procedures requiring PA, hospital office personnel must determine that the physician has completed all of the necessary PA forms. The primary surgeon has the responsibility of obtaining PA from the EDS Prior Approval Unit or DMA staff, as appropriate.

   Note: All behavioral health services for individuals in the Piedmont Cardinal Health Plan (PCHP) catchment area, with the exception of emergent treatment, must be authorized by the PCHP. (The catchment area covers Cabarrus, Davidson, Rowan, Stanly, and Union counties.)
5. Behavioral health referrals for outpatient services for children may be obtained from the local management entity, Medicaid-enrolled psychiatrist, or the primary care physician. This is not an authorization. It is a referral process that must take place **before** the provider sees the child. Authorization must be obtained from ValueOptions.

   For psychiatric services, the admissions are usually emergent, and the hospital has 48 hours to obtain PA from ValueOptions. All other mental health services require PA from ValueOptions as well.
6. Some requests for PA are submitted to DMA or DMA's authorizing agents [such as The Carolinas Center for Medical Excellence (CCME), ValueOptions, ACS State Healthcare, etc.], but most requests are submitted to Medicaid's fiscal agent, EDS. A few PA requests may be approved verbally by the fiscal agent and followed up with a written request. However, when a request for PA may be made verbally to the fiscal agent and it can be approved, the request is approved **tentatively** effective the date of the call, contingent upon receipt of the written request within 10 days of the call to the fiscal agent and validation that the documentation submitted by the provider substantiates the verbal information. If the written request is not received in the required time or the written documentation does not substantiate the verbal information previously provided, the request will be denied. Following the required timeframes, a new PA request may be submitted at any time. Please see the PA table at the end of this section to determine which services may receive **tentative** verbal PA.

7. Some requests for PA are submitted to DMA or DMA's authorizing agents (such as CCME, ValueOptions, ACS State Healthcare, etc.], but most requests are submitted to Medicaid's fiscal agent, EDS. A few PA requests may be approved verbally by the fiscal agent and followed up with a written request. However, when a request for PA may be made verbally to the fiscal agent and it can be approved, the request is approved **tentatively** effective the date of the call, contingent upon receipt of the written request within 10 days of the call to the fiscal agent. If the written request is not received in the required time, the request will be denied. Following the required timeframes, a new PA request may be submitted at any time. Please see the PA table at the end of this section to determine which services may receive **tentative** verbal PA. When emergent out-of-state services are provided, Medicaid or the appropriate approval **agency must be notified within 24 to 48 hours of service provision.** Out-of-state services must be provided in compliance with all applicable rules, regulations, laws, and current standards of practice.
8. **Except in emergency situations, all services provided to Medicaid recipients by out-of-state providers must be approved prior to rendering the service. Emergency coverage ends as soon as the recipient is stable. Medicaid will not pay for out-of-state services once a recipient is stable.**
9. The AVR system provides information regarding a recipient's last routine eye exam or refraction only. It is in the provider's best interest to obtain an authorization/confirmation number on the day of service, prior to rendering the service.
10. DMA staff and vendors will make every effort possible to make a decision about a PA request within 15 business days. There may be times when a request for PA does not contain sufficient information for Medicaid to determine whether the request should be approved or denied. In that event, Medicaid notifies the recipient and provider in writing that the request lacks the necessary documentation to review the request and specifies the deadline date for submission of additional information by the provider as well as where and how to submit the information. The provider must submit additional documentation as specified by Medicaid staff or contractors within 15 business days of the date of the notice for additional information.

    Medicaid recognizes that there may be situations when 15 business days are not sufficient time for a response. If a provider is unable to submit the additional information within 15 business days from the date of the request, s/he must contact Medicaid or its contractors to request a time extension. It is not necessary for the provider to explain the reason for the time extension. Medicaid allows the provider no more than an additional 15 business days from the date of the contact to submit the requested information. If there is no response from the provider or if the provider does not submit the additional information within the 15-business-day time period, the provider and recipient are notified in writing that the request was denied for insufficient information.
11. The table that appears at the end of this section summarizes information about some services that require PA. For complete information, refer to individual clinical coverage policies on DMA's website at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

Early and Periodic Screening, Diagnostic and Treatment

For a more detailed explanation of EPSDT, see DMA's EPSDT Policy Instructions Update at: http://www.ncdhhs.gov/dma/EPSDTprovider.htm and **Section 2, Recipient Eligibility.**

1. If the service, product, or procedure requires PA, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for PA.
2. If the recipient under 21 years of age does not meet the coverage criteria set forth in the clinical coverage policy, the provider must request and obtain PA from the appropriate authorizing agent **BEFORE** the service is rendered, whether or not PA is required.

3. If the service, product, or procedure is **NOT** one for which PA is required but the recipient under 21 years of age needs to exceed established limits, the provider must request and obtain PA from the appropriate authorizing agent (such as EDS, ValueOptions, CCME, DMA, etc.) **BEFORE** the limit is exceeded. Please refer to the PA table at the end of this section to determine the appropriate authorizing agent.
4. PA requests for non-covered state Medicaid plan services are requests for services, products, or procedures not included in the North Carolina State Medicaid Plan **but coverable** (medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination) under federal Medicaid law, 1905(r) of the Social Security Act. To review the listing of federal EPSDT services, products, or procedures coverable under federal Medicaid law, see the listing of EPSDT services at the end of this section.
5. Requests to cover non-covered state Medicaid plan services must be submitted to DMA prior to rendering the service**.**
6. EPSDT PA authorization is time limited to the first of the following occurrences:
   a. the recipient reaches 21 years of age **OR**
   b. the time limit specified by the PA is exhausted **OR**
   c. 365 days elapses from the date of the PA.
7. If the recipient is **over 21 years of age and the service has not been provided,** although PA was granted before his or her 21st birthday, follow DMA's published procedures and submit a new request for PA if PA is required. See the specific clinical coverage policy for complete details regarding provision of and payment for services rendered. Clinical coverage policies can be found on DMA's website at http://www.ncdhhs.gov/dma/mp/mpindex.htm.
8. If the recipient is **under 21 years of age and the authorization has expired** and if the service, product, or procedure is still desired and is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening, submit a new request for PA. See the specific clinical coverage policy for complete details regarding provision of and payment for services rendered. Clinical coverage policies can be found on DMA's website at http://www.ncdhhs.gov/dma/mp/mpindex.htm.
9. The provider has up to 365 days from the date the service is rendered to submit the claim for payment. See the specific clinical coverage policy for complete details regarding provision of and payment for services rendered. Clinical coverage policies can be found on DMA's website at http://www.ncdhhs.gov/dma/mp/mpindex.htm.
10. The service must be rendered in accordance with the PA granted, including service approved, number of units approved, and time period of approval, if relevant.
11. If PA is required, the provider must request and obtain PA **before** rendering the service, product, or procedure in order to seek Medicaid payment. Remember, obtaining PA does not guarantee payment or ensure recipient eligibility on the date of service. The recipient must meet clinical policy coverage criteria, where applicable, and must be Medicaid eligible on the date the service, product, or procedure is provided.
12. The request form may be found at the end of this section or on DMA's website at http://www.ncdhhs.gov/dma/formsprov.html. Recipients may also obtain a request form by calling the CARE-LINE Information and Referral Services (Monday through Friday, except state holidays) at the numbers specified below.

Research Triangle Area (Raleigh–Durham–Chapel Hill vicinity)

English/Spanish	919-855-4400
TTY number for the deaf or hearing impaired	919-733-4851

Outside Triangle Area

English/Spanish	800-662-7030
TTY number for the deaf or hearing impaired	877-452-2514

General Requests for Prior Approval

The Request for Prior Approval (form 372-118) is used by several service types to assist in the review of medical necessity for the requested services. PA requests must be submitted in writing using this form. To obtain this form, contact EDS Provider Services at 1-800-688-6696. Once a PA has been issued, it must be used within the time limit set forth by the PA **OR** within 365 days, whichever time period is less. The following services use this form:

- Some medical and surgical services
- Out-of-state elective services
- Services to Medicaid for Pregnant Women recipients
- Hearing aid services
- Therapeutic leave over 15 consecutive days
- Routine eye exam or refraction services beyond established limitations
- Out-of-state and state-to-state ambulance service

  Note: A completed and signed State-to-State Ambulance Transportation Addendum Form (372-118A) must accompany the PA request.
- Transplants (See "Procedures for Approval and Reimbursement of Transplants" in this section)

If Medicaid's fiscal agent (EDS) is the authorizing agent, mail the completed form to

EDS—Prior Approval Unit
P.O. Box 31188
Raleigh NC 27622

Requests approved by other authorizing agents must be submitted to that agent. See the PA table at the end of this section to determine the authorizing agent. It is also important to remember that if services are to continue and the PA is time limited, PA must be requested again before the limits are met to avoid an interruption in service and payment.

Denial of Prior Approval

A decision on a request for PA will be acted on with reasonable promptness (usually within 15 business days of receipt of the request). The provider will be notified in writing of a PA, denial, or any reduction or termination of services using the prescribed state form, and the recipient will be notified in writing of any denial, reduction, or termination of services. When a decision is made to deny, reduce, or terminate services for a recipient under 21 years of age, the decision will specify the reasons that the EPSDT standard is not met. The notice will be issued in accordance with DMA's recipient notices procedures. Such a denial can be appealed in the same manner as any Medicaid service denial, reduction, or termination.

Requests for Specific Types of Prior Approval

Adult Care Home – Enhanced Care

The Adult Care Home (ACH) staff makes a referral request for enhanced care on behalf of the recipient to the county department of social services (DSS) by sending a copy of the latest FL2, the **Adult Care Home Personal Care Services Physician Authorization and Plan of Care Form** (DMA-3050R), and other referral documents, as necessary. The county DSS assigns a case manager, conducts an independent assessment, and approves the recipient for enhanced care services, if appropriate. The case manager calls this approval in to the fiscal agent, receives a service review number, and sends the resident and the provider a decision notice.

Adult Care Home – Special Care Unit for Persons with Alzheimer's and Related Disorders

Effective October 1, 2006, Medicaid implemented a special care rate for ACH providers operating special care units for persons with Alzheimer's and related disorders (SCU-A). The provider must receive PA before admitting a new resident to a SCU-A. The provider must complete the SCU-A Prior Approval Form and submit it, along with all supporting documents, to

Adult Care Homes Unit
Facility and Community Care Section
Division of Medical Assistance
2501 Mail Service Center
Raleigh NC 27699-2501

The PA request form and instructions can be found on DMA's website at http://www.ncdhhs.gov/dma/formsprov.html, under Adult Care Homes.

Augmentative and Alternative Communication Devices

Submit a completed **Non-Covered State Medicaid Plan Services Request Form** to DMA, Assistant Director, Clinical Policy and Programs as specified on the form before providing the service, product, or procedure. The form must be completed by the recipient's physician or other licensed clinician. The request must include documentation that shows that **all** EPSDT criteria are met.

Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair

Children's Special Health Services (CSHS) is no longer responsible for reviewing prior approval for cochlear and auditory brainstem implant parts replacement and repair. All requests for external parts replacement and repair must be faxed, in letter format, to the appropriate cochlear or auditory brainstem implant manufacturer. The manufacturer will process requests, obtain prior approval for external speech processors, and file claims. Guidelines for the letter requesting external parts replacement or repair can be obtained from the cochlear or auditory brainstem manufacturer.

Community Alternatives Program Participation

The purpose of the Community Alternatives Program (CAP) is to offer community-based care to certain targeted populations as an alternative to institutionalization, as long as the care required can be delivered safely and is cost effective. Admission to and continuation of CAP services requires physician approval and is overseen by a CAP case manager. Admission to the program begins with the following:

1. Referral to the program

2. Completion of an FL2 signed and dated by the recipient's physician and approved at the nursing facility level of care (for CAP/C, CAP/Choice, and CAP/DA) or completion of an MR2 signed and dated by the recipient's physician and approved at the intermediate care facility for individuals with mental retardation level of care (for CAP/MR-DD).

   Note: Case managers are encouraged to submit the FL2 electronically.
3. Thorough assessment of the recipient to determine appropriateness for CAP
4. Evaluation of the assessment and level of care document to determine appropriateness for CAP

The CAP programs, lead agencies, and websites are identified below.

Program	Lead Agency	Website
CAP/C	DMA–Home Care Initiatives Unit	http://www.ncdhhs.gov/dma/cc/capc.htm
CAP/DA	Appointed County Agency	Lead agency listing: http://www.ncdhhs.gov/dma/commaltprog.htm
CAP/MR-DD	Division of Mental Health, Developmental Disabilities and Substance Abuse Services (MHDDSAS)	http://www.ncdhhs.gov/mhddsas/cap-mrdd/index.htm

Further information about CAP is available in specific clinical coverage policies, program manuals, and the websites specified above.

Dental Services

Requests for PA for dental services are submitted using the 2006 ADA form. Only PA requests for services that are indicated as requiring PA should be submitted to the EDS Prior Approval Unit. Refer to the Dental Program Policy Manual (#4A, *Dental Services*, and #4B, *Orthodontic Services*) on DMA's website at http://www.ncdhhs.gov/dma/mp/mpindex.htm for information on dental services and limitations.

The two-part form must be used when requesting PA. The original is returned to the provider and serves as the PA/claim copy. The second page is retained by EDS. Until the original is returned, providers should keep a copy for their office records, noting the date the PA request was mailed.

Durable Medical Equipment, Including Pediatric Mobility Aids, and Orthotic and Prosthetic Devices

Some DME items and orthotic and prosthetic devices (O&P) require PA. In those cases, the **Certificate of Medical Necessity/Prior Approval (CMN/PA) form** must be submitted to EDS for review. The CMN/PA is reviewed to ensure that the item is medically necessary to maintain or improve a recipient's medical, physical, or functional level and that it is suitable and appropriate for use in the recipient's private residence or adult care home.

PA requests for DME and O&P that do not appear on DMA's lists of covered equipment but are medically necessary under EPSDT should be submitted to DMA at

Assistant Director
Clinical Policy and Programs
Division of Medical Assistance
2501 Mail Service Center
Raleigh NC 27699-2501
FAX: (919) 715-7679

PA is valid for the time period approved on the CMN/PA form. If a physician decides that an item is needed for a longer period of time, a new CMN/PA form must be submitted.

Refer to clinical coverage policies #5A, *Durable Medical Equipment,* and #5B, *Orthotic and Prosthetic Devices,* on DMA's website at http://www.ncdhhs.gov/dma/mp/mpindex.htm for additional information.

Hearing Aids, Frequency Modulation Systems, and Accessories

All hearing aids, frequency modulation (FM) systems, repairs, replacement parts, and accessories require PA. Requests must be submitted using the general Request for Prior Approval (form 372-118) along with a letter from the physician or otologist (including otolaryngologist or otorhinolaryngologist) certifying the need for beginning the hearing aid selection process, a copy of a hearing evaluation (including audiogram), the results of the hearing aid selection and evaluation tests, and a copy of the hearing aid manufacturer's warranty information.

- In block 10 on the PA, record the manufacturer, model, and cost of requested aid.
- Also in block 10, document the type of aid being requested (Analog Programmable, Digital Programmable, or FM System).
- In block 12, document the reason(s) the recipient requires the requested system.

Refer to Clinical Coverage Policy #7, *Hearing Aid Services,* on DMA's website at http://www.ncdhhs.gov/dma/mp/mpindex.htm for information on services and limitations.

Hospice Participation

Hospice providers must notify EDS when a Medicaid recipient elects the hospice benefit as well as when hospice benefits are revoked, a recipient is discharged from hospice, or a recipient transfers from one hospice to another. This includes Medicare/Medicaid hospice patients in nursing facilities for whom Medicaid is paying room and board. Hospice participation information may also be obtained using the AVR system.

Refer to **Appendix A** for information about using the AVR system.

Long-Term-Care Services

The **FL2 Long-Term-Care Services form** (372-124 paper; FL2e electronic) is used by several programs for approval of long-term-care nursing services. If a telephone review results in approval of the FL2, the approval is **tentative (not final),** pending submission of a completed form within 10 days of the telephone call to the fiscal agent and validation that the documentation submitted substantiates the verbal information previously provided. The FL2 must be submitted as the hard copy original or electronically through Provider Link. Should the submitted FL2/FL2e fail to validate that the recipient requires nursing facility level of care at the level specified by the requestor and in accordance with DMA's recipient notices procedure, the request may be denied or reduced, or additional information may be requested. Additionally, if the FL2/FL2e is not submitted within the required timeframe, the FL2/FL2e will be denied. The following services use this form:

- Out-of-state long-term care (nursing facility)

- Long-term-care nursing
- Ventilator-dependent care
- CAP/C, CAP/Choice, CAP/DA for level of care determinations

Providers are encouraged to submit the FL2 electronically. All electronic requests for long-term-care nursing services must be submitted through Provider Link using the FL2e form.

Optical Services—Routine Eye Exams with Refractions

Routine eye exams with refractions do not require PA. However, it is in the best interest of the provider to call the AVR system to verify the last date of service and receive an authorization/confirmation number for the patient record. If a second routine eye exam with refraction or a refraction only is requested within the time limitation period, PA is required. A **general Request for Prior Approval form** (372-118) documenting medical necessity must be submitted and approved prior to rendering the service.

Refer to **Appendix A** for information about using the AVR system to obtain PA for eye exams with refractions.

Optical Services—Visual Aids

All visual aids require PA, and requests must be submitted on a **Request for Prior Approval for Visual Aids form** (372-017 or 372-017A). To obtain this form, contact EDS Provider Services at 1-800-688-6696. In some cases, this form must be accompanied by required documentation. Refer to the *Optical Services Manual* on DMA's website at http://www.ncdhhs.gov/dma/optical.htm for information on services and limitations.

Oral Nutrition Products

Submit a completed **Non-Covered State Medicaid Plan Services Request Form** to DMA, Assistant Director, Clinical Policy and Programs as specified on the form before providing the service, product, or procedure. The form must be completed by the recipient's physician or other licensed clinician. The request must include documentation that shows that **all** EPSDT criteria are met.

Out-of-State or State-to-State Ambulance Service

PA is required for ambulance service by ground or air from North Carolina to another state, from one state to another, or from another state back to North Carolina. PA for ambulance service is separate from PA for a medical procedure or treatment provided out of state. Requests for PA must be submitted on the **general Request for Prior Approval form** (372-118) and the **State-to-State Ambulance Transportation Addendum form** (372-118A).

If emergent services are required, Medicaid or the appropriate approval agency must be notified within 24 to 48 hours of service provision. Services must be provided in compliance with all applicable rules, regulations, laws, and current standards of practice.

Outpatient Specialized Therapies

N.C. Medicaid contracts with CCME to perform the PA process for outpatient specialized therapies. PA is required for treatment services. There are six unmanaged visits per discipline, per provider type or 6-month exemption from PA once in a lifetime. It is always safer to obtain PA since you may not be aware of previous services.

If treatment is to continue after the six unmanaged visits or 6-month exemption, the PA request should be made at approximately the second or third unmanaged visit to allow sufficient time for processing. **Prior**

Authorization Requests for Outpatient Specialized Therapy Services may be faxed to CCME at 1-800-228-1437 or submitted electronically for treatment to be continued. If appropriate, CCME will authorize services for a specific number of units through a specific length of time. Units should be requested based on the CPT code billed. A copy of the form and electronic submission instructions are available on CCME's website at https://www2.mrnc.org/priorauth/pages/Home.aspx. Once the limits have been reached, PA must be requested again for continued treatment.

Refer to Clinical Coverage Policy #10A, *Outpatient Specialized Therapies*, on DMA's website at http://www.ncdhhs.gov/dma/mp/mpindex.htm for additional information.

Over-the-Counter Medications

Requests for coverage of over-the-counter (OTC) medications that are not on the list of OTC medications covered by the North Carolina State Medicaid Plan should be submitted to the DMA, Assistant Director, Clinical Policy and Programs using the **Non-Covered State Medicaid Plan Services Request Form** as specified on the form prior to providing the medication. The form must be completed by the recipient's physician or other licensed clinician. The request must include documentation that shows that **all** EPSDT criteria are met. Coverage consideration will be given for an OTC medication for which a National Drug Code (NDC) exists and for which the medication's manufacturer has a valid rebate agreement with the Centers for Medicare and Medicaid Services (CMS).

Refer to General Coverage Policy #A-2, Over-the-Counter Medications, on DMA's website at http://www.ncdhhs.gov/dma/mp/mpindex.htm for a current list of covered OTC medications.

Prescription Drugs

N.C. Medicaid contracts with ACS State Healthcare to manage the PA process for the drugs listed below. Additional drugs requiring PA may occasionally be added. Providers will be notified of these changes via the general Medicaid bulletin (http://www.ncdhhs.gov/dma/bulletin.htm) and/or through the Pharmacy Newsletter (http://www.ncdhhs.gov/dma/pharmnews.htm).

- Botox, Myobloc
- Celebrex
- Growth hormones
- Procrit, Epogen, Aranesp
- Proton pump inhibitors
- Provigil
- Sedative hypnotics
- Brand-name Schedule II narcotics
- Second generation antihistamines

The prescriber contacts the ACS Clinical Call Center (in Henderson, North Carolina) directly by telephone, fax, e-mail, or mail. Pharmacists may dispense a 72-hour emergency supply without PA.

Copies of the prescription PA forms may be obtained by contacting ACS State Healthcare (telephone 1-866-246-8505 or online at http://www.ncmedicaidpbm.com).

Transplants

When a hospital transplant team determines that a recipient requires a transplant (solid organ or stem cell), all of the supporting documentation justifying the medical necessity for the procedure must be sent to DMA for pre-approval **regardless of where Medicaid is in the payment priority.** After the documentation is reviewed, the physician and the facility will receive a notification of approval or denial from DMA.

Retroactive PA will not be authorized for any recipient who does not have Medicaid coverage at the time of the procedure, except when a recipient is later approved for Medicaid with a retroactive eligibility date.

In order for N.C. Medicaid to review a request for transplant coverage for a dually eligible recipient, providers must submit a copy of the insurance denial or payment from the primary payer with the claim, the request for coverage of the transplant service, and the complete clinical evaluation packet. These must be received within 180 days of the transplant procedure. Requests without complete clinical evaluation packets will not be considered. Upon receipt of these documents, DMA will conduct a dually eligible post review and make a determination, using clinical policy guidelines, as to whether Medicaid coverage is available. Clinical packets **must** be complete, according to the requirements below, in order to be reviewed.

Fax clinical packets to the transplant nurse consultant at 919-715-0051. The packet must include the documentation specified below as well as the clinical documentation indicated in the specific transplant clinical coverage policies, available on DMA's website at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

Solid Organ Transplant Packets

- Letter from physician requesting transplant and summarizing clinical history
- All recent lab results (refer to organ-specific policy criteria for a list of applicable lab tests)

  Note: No lab results can be more than 3 months old.
- All recent diagnostic and procedure results (**not** more than 3 months old)
- Complete psychological and social evaluation with documentation of post-transplant care needs of patient and/or family, as indicated, that accurately depict support, compliance, etc.
- Recipients with a psychiatric history are required to have a psychiatric evaluation
- Recipients with a history of or active substance abuse are required to show documentation of substance abuse program completion and 6 months of negative sequential random drug and alcohol screens

  Note: To satisfy the requirement for sequential testing as designated by policy, DMA must receive a series of test (alcohol and drug) results spanning at least 6 months, with no fewer than a 3 weeks and no more than 6 weeks between tests during the given time period. A complete clinical packet must include at least one documented test performed within 1 month of the date of the request in order to be considered for PA.
- Other organ-specific policy criteria (http://www.ncdhhs.gov/dma/mp/mpindex.htm; see the clinical coverage policies in group 11B)

Additional clinical or other documentation may be requested.

Stem Cell Transplant Packets

- Letter from physician requesting transplant and summarizing clinical history
- Previous chemotherapy regimes and dates
- All recent lab results (refer to disease-specific policy criteria for a list of applicable lab tests)

  Note: No lab results can be more than 3 months old.
- All diagnostic and procedure results, including bone marrow aspiration (**not** more than 3 months old)
- Complete psychological and social evaluation with documentation of post-transplant care needs of patient and/or family, as indicated, that accurately depict support, compliance, etc.
- Recipients with a psychiatric history are required to have a psychiatric evaluation

- Recipients with a history of or active substance abuse are required to show documentation of substance abuse program completion and 6 months of negative sequential random drug and alcohol screens as specified above.
- Other disease-specific policy criteria (http://www.ncdhhs.gov/dma/mp/mpindex.htm; see the clinical coverage policies in group 11A)

Additional clinical or other documentation may be requested.

Lab results required in a complete packet include CBC, liver enzymes, complete electrolytes, PT, INR, HIV, Hep, RPR, EBV, CMV, Varicella, rubella, T protein, Ca, BUN, HSV I/II amylase, lipase, phosp, mag, AFP (depending on the diagnosis), glucose and AIC, cholesterol and trig (depending on history), blood type, MELD/PELD score, LD, uric acid, T. bili, GGT, and recipient height and weight. Other lab tests may be requested.

Utilization Review for Psychiatric Services

N.C. Medicaid contracts with ValueOptions to provide utilization review of acute inpatient/substance abuse treatment hospital care, psychiatric residential treatment facilities (PRTFs), Levels II through IV residential treatment facilities, outpatient psychiatric services, enhanced benefits, and Criterion 5. ValueOptions reviews and approves the requests based on medical necessity according to established criteria.

For recipients **over 21 years of age** and after the eighth visit, providers must obtain authorization from ValueOptions for continued outpatient mental health services. Recipients **under 21 years of age** are allowed 26 unmanaged visits before PA is required.

Copies of the PA form can be obtained by calling ValueOptions at 1-888-510-1150.

Refer to the May 2006 Special Bulletin, *Enhanced Benefit Mental Health/Substance Abuse Services,* on DMA's website at http://www.ncdhhs.gov/dma/bulletinspecial.htm, for additional information.

Session Law 2008-207, known as the Appropriations Act of 2008, was approved on July 16, 2008. It contains various requirements that affect the provision of Community Support Services. A brief overview of Section 10.15A (Improve and Strengthen Fiscal Oversight of Community Support Services) of the Act appears below.

Section 10.15A(i)–ALL Community Support Services are subject to prior approval. As a result of this provision

1. The unmanaged 4 hours for adults and 8 hours for children are now disallowed (as of August 1, 2008).
2. Medicaid payment cannot be authorized for provision of service when services are not authorized prior to delivery.

Section 10.15A(j)–The maximum allowable hours of Community Support Services is 8 hours per week, or 416 units over a 90-day period. This is a hard benefit limit for adult recipients (21 years of ages and older). Again, as a result of this provision and as noted above, Medicaid payment will not be authorized for services to adults (21 years of ages and older) that exceed this limit.

Note: Under Early Periodic Screening, Diagnosis and Treatment (EPSDT) regulations governing Medicaid services for children (recipients under 21 years of age), Medicaid may not have a hard benefit limit on children's services. However, any request for more than 8 hours per week of Community Support Services for a child will require an additional review to ensure that EPSDT criteria and conditions are met. If the request is not fully documented to show that all EPSDT criteria are met, ValueOptions may issue a request for additional information. In order to expedite the review, providers

are encouraged to submit any additional clinical information, assessments, or supporting documentation, including but not limited to evidence-based literature, along with the inpatient treatment record (ITR) or the person centered plan (PCP) to support that Community Support Services and the additional hours requested over the policy limit are medically necessary and that the EPSDT criteria are met. Please note that EPSDT requirements do not override prior authorization requirements.

See the EPSDT information found in **Section 2, Recipient Eligibility,** or the EPSDT Policy Instructions Update on DMA's website at http://www.ncdhhs.gov/dma/EPSDTprovider.htm for a full discussion of EPSDT and criteria.

Quick Reference Table—Prior Approval for Certain Medicaid Services

More detailed information about most entries in this table is printed in the front of this section.

Service	Verbal Authorization	Written Authorization
Augmentative and Alternative Communication Devices	No verbal authorization.	Submit completed Non-Covered State Medicaid Plan Services Request to DMA as specified on the form **before** providing the service, product, or procedure. The form must be completed by the recipient's physician or other licensed clinician. The request must show that **ALL** EPSDT criteria are met.
CAP/MR-DD	Call the local management entity in the recipient's county of residency for assistance in the assessment and referral process	A completed MR2 signed by an LME representative and a physician or licensed clinical psychologist must be submitted to the Specialized Services Department at the Murdoch Center by the local management entity. Refer to the CAP/MR-DD manual at http://www.ncdhhs.gov/mhddsas/cap-mrdd/index.htm
Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair	No verbal authorization.	Requests for external parts replacement and repair must be faxed, in letter format, to the appropriate cochlear or auditory brainstem implant manufacturer.
Durable Medical Equipment, including pediatric mobility systems	No verbal authorization.	Complete a CMN/PA form [372-131 (8/02)] and submit to EDS.

Service	Verbal Authorization	Written Authorization
EPSDT: State Medicaid Plan Services for Recipients under 21 Years of Age	No verbal authorization.	If services to be provided exceed covered limitations, submit a completed applicable program PA form(s) to the appropriate authorizing agent along with documentation that shows the request will correct or ameliorate a defect, physical or mental illness, or a condition identified by a licensed clinician and any other documentation to show that all EPSDT criteria are met before providing the service. The reviewer will request additional information if needed.
EPSDT: Non-covered State Medicaid Plan Services for Recipients Under 21 Years of Age	No verbal authorization. **Important note**: This procedure is only for requesting services under EPSDT that are *never* otherwise covered under the N.C. Medicaid State Plan. To request covered services for recipients under 21 years of age in excess of numerical limits or other specific criteria in clinical coverage policies, see EPSDT for State Medicaid Plan Services immediately above.	Submit a completed Non-Covered State Medicaid Plan Services Request to DMA as specified on the form **before** providing the service, product, or procedure. The form must be completed by the recipient's physician or other licensed clinician. The request must show that **ALL** EPSDT criteria are met. The reviewer will determine if the request is a coverable service. If additional information is required, the reviewer will request it.
Hearing Aids and Accessories	No verbal authorization.	Complete a general Request for Prior Approval form (372-118) and submit to EDS.
Hospice	Call EDS (800-688-6696 or 919-851-8888) to report hospice benefit election.	Hospice election must be reported within 7 calendar days of the start of hospice services. PA for hospice reporting cannot be granted retroactively beyond the 7-day timeframe.

Service	Verbal Authorization	Written Authorization
Intermediate Care Facility for Persons with Mental Retardation	No verbal authorization.	For approval of this level of care, fax a completed MR2 signed by a physician, the local management entity and a qualified developmental disabilities professional, to the Murdoch Center at 919-575-1083, along with a current psychological evaluation, for approval of this level of care. If approved, Murdoch will secure a prior authorization number from EDS and transmit the PA number to the requester for transmittal to the department of social services and the facility where the recipient will reside.
Long-Term Care (FL2)	Call EDS (800-688-6696 or 919-851-8888) to receive tentative verbal approval.	The completed FL2 (hard copy original FL2 or electronic FL2e through Provider Link) must be received by EDS within 10 business days of the telephone call. Providers are encouraged to use FL2e.
Medicaid for Pregnant Women	No verbal authorization.	Complete a general Request for Prior Approval form (372-118) and/or appropriate referral form for the following services: Visual aids and eye exams Podiatric services DME Home health Hospice Personal Care Services (PCS) Private duty nursing (PDN) Home infusion therapy Chiropractic services
Optical Services – Routine Eye Examinations with Refractions	PA not required. Call the AVR system (800-723-4337; alternate 800-688-6696) for the last date of service and an authorization/ confirmation number.	Complete a general Request for Prior Approval form (372-118) for medically necessary exceptions to the time period limitations and submit to EDS.
Optical Services – Visual Aids	No verbal authorization.	Complete Prior Approval Request for Visual Aids form (372-017 or 372-017A) and submit to EDS. Include documentation of medical necessity for exceptions.

Service	Verbal Authorization	Written Authorization
Oral Nutrition Products	No verbal authorization.	Submit completed Non-Covered State Medicaid Plan Services Request to DMA as specified on the form before providing the service, product, or procedure. The form must be completed by the recipient's physician or other licensed clinician. The request must show that ALL EPSDT criteria are met.
Out-of-State Non-Emergent Services	No verbal authorization; call EDS (800-688-6696 or 919-851-8888) for information and instructions for obtaining out-of-state approval.	Complete a general Request for Prior Approval form (372-118) Add medical records and a letter from the attending physician requesting out-of-state services and stating why the services cannot be provided in North Carolina. Fax requests to 919-233-6834.
Out-of-State Emergent Services	No verbal authorization; call EDS (800-688-6696 or 919-851-8888) within **24 to 48 hours following service provision** regarding information and instructions for obtaining out-of-state approval and transporting the recipient to North Carolina as soon as stable. Once stable and if need be, N.C. Medicaid will determine how and where the recipient should be transported.	
Out-of-State and State-to-State Ambulance Services	No verbal authorization; call EDS (800-688-6696 or 919-851-8888) to receive information and instructions regarding obtaining out-of-state and state-to-state ambulance services approval **prior** to transport. **If transport needs are emergent, contact EDS within 24 to 48 hours following provision of service.**	Complete a general Request for Prior Approval form (372-118) and an Out-of-State and State-to-State Ambulance Transportation Addendum form (372-118A). Follow EDS instructions for when and how to submit the request.
Outpatient Specialized Therapies	No verbal authorization.	Fax (800-228-1437) or electronically submit (https://www2.mrnc.org/priorauth/pages/Home.aspx) a Prior Approval for Outpatient Specialized Therapies form to CCME.

Service	Verbal Authorization	Written Authorization
Over-the Counter (OTC) Medications	No verbal authorization.	Submit completed Non-Covered State Medicaid Plan Services Request to DMA as specified on the form before providing the service, product, or procedure. The form must be completed by the recipient's physician or other licensed clinician. The request must show that ALL EPSDT criteria are met.
Prescription Drugs	Call ACS State Healthcare (866-246-8505) for information and instructions.	Fax completed Pharmacy PA forms to ACS State Healthcare (866-246-8507).
Private Duty Nursing (PDN)	Call DMA (919-855-4380) for PDN consultation. Upon review of faxed information, the PDN consultant will provide verbal authorization as indicated.	Complete and fax a PDN Referral form and a Physician's Request form (both online at http://www.ncdhhs.gov/dma/forms.html) documenting medical necessity to DMA (919-715-9025).
Psychiatric Services, Inpatient (PRTF, Residential Child Care, Criterion 5, Out-of-State and Residential Services)	Call ValueOptions (888-510-1150) for information and instructions.	Submit documentation in accordance with behavioral health clinical coverage policies online at http://www.ncdhhs.gov/mp/mpindex.htm.
Psychiatric Services, Outpatient (Enhanced Benefit Services, Developmental Disability)	Call ValueOptions (888-510-1150) for information and instructions.	Submit documentation in accordance with behavioral health clinical coverage policies online at http://www.ncdhhs.gov/mp/mpindex.htm.
Surgery	No verbal authorization; call EDS (800-723-4337) to verify if a surgery requires PA.	Complete a general Request for Prior Approval form (372-118) and submit to EDS. Include documentation supporting medical necessity as specified in individual clinical coverage policies.

Service	Verbal Authorization	Written Authorization
Therapeutic Leave for Nursing Facilities	Approval for therapeutic leave in excess of 15 consecutive days is required. Call EDS (1-800-688-6696 or 919-851-8888) to receive tentative approval.	Complete a general Request for Prior Approval form (372-118) and submit to EDS. Include supporting documentation. Therapeutic leave must be a part of the resident's plan of care, ordered by his/her attending physician, with therapeutic justification for each instance of such leave entered into the resident's medical record.
Therapeutic Leave for ICF/MRs	Verbal approval for therapeutic leave in excess of 15 consecutive days is required. Call EDS (1-800-688-6696 or 919-851-8888) to receive approval.	Written authorization is not required. However, therapeutic leave must be a part of the resident's plan of care, ordered by his/her attending physician, with therapeutic justification for each instance of such leave entered into the resident's medical record.
Therapeutic Leave for Residential Child Care Facilities and PRTFs	Not required.	Authorization is not required. However, therapeutic leave is limited to no more than 15 days per calendar quarter and must be documented in the resident's plan of care and therapeutic justification for each instance of such leave entered into the resident's medical record.
Tocolytic Infusion Therapy	No verbal authorization.	Complete a Tocolytic Prior Approval Request Form (online at http://www.ncdhhs.gov/dma/forms.html) and fax to CCME (919-380-9457). Include applicable supporting documents.
Transplants	No verbal authorization.	Fax completed packets/requests to the DMA transplant nurse consultant (919-715-0051).

Listing of EPSDT Services Found at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]

- Inpatient hospital services (other than services in an institution for mental disease)
- Outpatient hospital services
- Rural health clinic services (including home visits for homebound individuals)
- Federally-qualified health center services
- Other laboratory and X-ray services (in an office or similar facility)
- EPSDT *(Note: EPSDT* offers periodic screening services for recipients under age *21 and Medicaid covered services* necessary to correct or ameliorate a *diagnosed physical* or mental condition)
- Family planning services and supplies
- Physician services (in office, recipient's home, hospital, nursing facility, or elsewhere)
- Medical and surgical services furnished by a dentist
- Home health care services (nursing services; home health aides; medical supplies, equipment, and appliances suitable for use in the home; physical therapy, occupation therapy, speech pathology, audiology services provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services)
- Private duty nursing services
- Clinic services (including services outside of clinic for eligible homeless individuals)
- Dental services
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- Prescribed drugs
- Dentures
- Prosthetic devices
- Eyeglasses
- Services in an intermediate care facility for the mentally retarded
- Medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law, specified by the Secretary (also includes transportation by a provider to whom a direct vendor payment can appropriately be made)
- Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level
- Inpatient psychiatric hospital services for individuals under age 21
- Services furnished by a midwife, which the nurse-midwife is legally authorized to perform under state law, without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider throughout the maternity cycle
- Hospice care

- Case management services
- TB-related services
- Respiratory care services
- Services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner, which the practitioner is legally authorized to perform under state law
- Personal care services (in a home or other location) furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease
- Primary care case management services

Definitions of the above federal Medicaid services can be found in the Code of Federal Regulations 42 CFR 440.1-440.170 at http://www.access.gpo.gov/nara/cfr/waisidx_06/42cfr440_06.html.

North Carolina
Department of Health and Human Services
Division of Medical Assistance
2501 Mail Service Center - Raleigh, N.C. 27699-2501

Michael F. Easley, Governor
Dempsey Benton, Secretary

William W. Lawrence, Jr., M.D., Acting Director

FORM AVAILABLE ON DMA WEB SITE AT http://www.ncdhhs.gov/dma/forms.html

NON-COVERED STATE MEDICAID PLAN SERVICES REQUEST FORM
FOR RECIPIENTS *UNDER* 21 YEARS OF AGE

RECIPIENT INFORMATION: ***Must be completed by physician, licensed clinician, or provider.***

NAME: _____
DATE OF BIRTH: ____/____/____ *(mm/dd/yyyy)* **MEDICAID NUMBER:** _____
ADDRESS: _____
_____

MEDICAL NECESSITY: ***ALL REQUESTED INFORMATION, including CPT and HCPCS codes, if applicable, as well as provider information must be completed. Please submit medical records that support medical necessity.***

REQUESTOR NAME: _____	**PROVIDER NAME:** _____
MEDICAID PROVIDER #: _____	**MEDICAID PROVIDER #:** _____
ADDRESS: _____	**ADDRESS:** _____
_____	_____
TELEPHONE #: (____)_____	**TELEPHONE #:** (____)_____
FAX #: _____	**FAX #:** _____

IN WHAT CAPACITY HAVE YOU TREATED THE RECIPIENT ***(incl. length of time you have cared for recipient and nature of the care):*** _____
_____

PAST HEALTH HISTORY ***(incl. chronic illness):*** _____
_____

RECENT DIAGNOSIS(ES) RELATED TO THIS REQUEST ***(incl. onset, course of the disease, and recipient's current status):*** _____
_____

TREATMENT RELATED TO DIAGNOSIS(ES) ABOVE ***(incl. previous and current treatment regimens, duration, treatment goals, and recipient response to treatment(s)):*** _____
_____

1 of 3 -OVER-

11/05
REV. 02/07
REV. 09/07

NAME:	MID #:	DOB:

NAME OF REQUESTED PROCEDURE, PRODUCT, OR SERVICE (if *applicable, please include CPT AND HCPCS codes*). PROVIDE DESCRIPTION RE HOW REQUEST WILL CORRECT OR AMELIORATE THE RECIPIENT'S DEFECT, PHYSICAL OR MENTAL ILLNESS OR CONDITION [THE PROBLEM]. THIS DESCRIPTION *MUST* INCLUDE A DETAILED DISCUSSION ABOUT HOW THE SERVICE, PRODUCT, OR PROCEDURE WILL IMPROVE OR MAINTAIN THE RECIPIENT'S HEALTH IN THE BEST CONDITION POSSIBLE, COMPENSATE FOR A HEALTH PROBLEM, PREVENT IT FROM WORSENING, OR PREVENT THE DEVELOPMENT OF ADDITIONAL HEALTH PROBLEMS.

_____
_____
_____
_____
_____
_____
_____
_____
_____

IS THIS REQUEST FOR EXPERIMENTAL/INVESTIGATIONAL TREATMENT:
___YES ___NO IF YES, PROVIDE NAME AND PROTOCOL #_____
_____

IS THE REQUESTED PRODUCT, SERVICE, OR PROCEDURE CONSIDERED TO BE SAFE:
___YES ___NO IF NO, PLEASE EXPLAIN._____
_____
_____
_____

IS THE REQUESTED PRODUCT, SERVICE OR PROCEDURE EFFECTIVE:__YES ___NO
IF NO, PLEASE EXPLAIN._____
_____
_____

ARE THERE ALTERNATIVE PRODUCTS, SERVICES, OR PROCEDURES THAT WOULD BE MORE COST EFFECTIVE BUT SIMILARLY EFFICIACIOUS TO THE SERVICE REQUESTED: ___YES ___NO IF YES, SPECIFY WHAT ALTERNATIVES ARE APPROPRIATE FOR THE RECIPIENT AND PROVIDE EVIDENCE BASE WITH THIS REQUEST, IF AVAILABLE._____
_____
_____
_____
_____

WHAT IS THE EXPECTED DURATION OF TREATMENT:
_____
_____

2 of 3 -OVER-

11/05
REV. 02/07
REV. 07/07

NAME:	MID #:	DOB:

OTHER ADDITIONAL INFORMATION:_____

_____

_____

_____

_____

_____

_____

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_____

_____

_____

_____

_____ _____

REQUESTOR'S SIGNATURE AND CREDENTIALS **DATE**

INCLUDE EVIDENCE-BASED LITERATURE TO SUPPORT THIS REQUEST IF AVAILABLE.

MAIL OR FAX COMPLETED FORM TO:

Assistant Director
Clinical Policy and Programs
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501
FAX: 919-715-7679

3 of 3

11/05
REV. 02/07
REV. 07/07